Dato' Dr V Thuraisingam & Anor v Sanmarkan a/l Ganapathy & Anor

COURT OF APPEAL (PUTRAJAYA) — CIVIL APPEAL NO P-02–2280–09 OF 2011
HAMID SULTAN, BADARIAH SAHAMID AND PRASAD ABRAHAM JJCA
15 JULY 2015

Tort — Negligence — Medical negligence — Whether trial court wrong to have found appellants negligent — Whether appellants acted reasonably and logically and got their facts right in their treatment of deceased — Whether trial court wrong to have determined 'standard of care' issue on its own without making finding on any of expert medical evidence tendered in case — Whether trial court gravely misdirected itself by not considering established guidelines set out in leading cases on medical negligence

The respondents, as administrators of the estate of Saradhamani a/p Doraisamy ('the deceased'), sued the appellants, who were consultant physicians, in the High Court for being medically negligent in their treatment of the deceased. Over a 20 year period from 7 January 1980–15 December 2000, the appellants had treated the deceased on seven occasions for food poisoning and gastroenteritis. On all those occasions, the deceased was admitted to the third defendant's hospital and she was discharged within 24 hours or so of admission after responding well to treatment. However, on 15 December 2000, when the deceased consulted the first appellant for abdominal pains and detailed tests were carried out, it was discovered that she had cancer of the colon. Five days thereafter, the deceased underwent surgery to remove part of the colon. She died five years later on 8 February 2005. In their suit, the respondents contended that the appellants were negligent in failing to diagnose, or in misdiagnosing, the deceased's colon cancer and because of that she underwent pain and suffering, surgery, and chemotherapy and radiation treatment until her death. The trial court found the appellants liable on the respondents' claim leading to the instant appeal against that decision with a cross-appeal by the respondents against quantum. In the appeal, the appellants argued that the history of the deceased's visits to them showed that the diagnosis, treatment and discharge in each instance were appropriate and that they had not been negligent. They contended that expert medical opinion supported their stand that symptoms had to persist for a reasonable length of time before investigation for colon cancer would be considered. The appellants submitted that the trial judge was wrong in, inter alia, (a) not considering the evidence of any of the expert medical witnesses who testified at the trial and determining the issue of negligence based on his own views (b) failing to

appreciate that six bouts of food poisoning in 20 years and nine months was not remarkable and did not, per se, impose a duty on the appellants to have carried out further investigation especially when the deceased's complaints on each occasion were resolved within 24 hours (c) failing to appreciate that it was the deceased's peculiar signs and symptoms on 15 December 2000 that led the first appellant to investigate further and discover the colon cancer.

Held, allowing the appeal, dismissing the cross-appeal and setting aside the judgment of the High Court:

(1) Re-looking the facts and the evidence and applying the guidelines set out by the Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 and taking into consideration that in 20 years almost all the complaints relating to the deceased during her eight visits were appropriately attended to by the appellants, it was this court's finding that no reasonable tribunal properly appraised of the facts and the law would have come to the conclusion that the appellants were liable. The court was satisfied the appellants had acted reasonably and logically and had gotten their facts correct (see para 57(c)).

(2) In the instant case three medical experts had given their opinion: PW1 for the respondents and DW3 and DW4 for the appellants. None of the expert evidence was discredited or expunged from the records. It was a grave misdirection on the part of the trial judge to have disregarded the medical expert opinion on the subject in issue to deal with 'standard of care' in particular relating to medical negligence, in breach of established guidelines set out in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; [1957] 1 WLR 582, *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151 as well as *Foo Fio Na*'s case. In addition, it also did not subscribe to the Evidence Act 1950. The trial judge's attempt to single-handedly deal with the issue of 'standard of care' without weighing all the medical experts' evidence undermined the integrity of the decision-making process requiring the appellate court to give no other alternative but to quash the decision in limine (see para 57(b)).

[Bahasa Malaysia summary

Responden-responden, sebagai pentadbir-pentadbir estet Saradhamani a/p Doraisamy ('si mati'), menyaman perayu-perayu, yang mana adalah perunding pakar perubatan, di Mahkamah Tinggi kerana cuai dalam rawatan mereka terhadap si mati. Dalam tempoh lebih 20 tahun dari 7 Januari 1980 sehingga 15 Disember 2000, perayu-perayu telah merawat si mati sebanyak tujuh kali bagi keracunan makanan dan radang perut dan usus. Pada kesemua masa tersebut, si mati telah dimasukkan ke hospital defendan ketiga dan dia telah dibenarkan keluar dalam masa 24 jam atau dibenarkan keluar selepas bertindak baik kepada rawatan. Walau bagaimanapun, pada 15 Disember 2000 apabila si

A mati menemui perayu pertama bagi sakit perut dan ujian terperinci telah dijalankan, dan didapati dia menghidapi kanser kolon. Lima hari kemudiannya, si mati menjalani pembedahan untuk membuang sebahagian daripada kolon tersebut. Dia meninggal dunia lima tahun kemudian pada 8 Februari 2005. Dalam guaman mereka, responden-responden berhujah B bahawa perayu-perayu adalah cuai kerana gagal untuk mendiagnosis atau membuat diagnosis yang tidak betul, kanser kolon si mati dan kerana itu dia mengalami kesakitan dan penderitaan, pembedahan, dan kemoterapi dan rawatan radiasi sehingga dia meninggal dunia. Mahkamah perbicaraan mendapati perayu-perayu bertanggungjawab ke atas tuntutan C responden-responden membawa kepada rayuan ini terhadap keputusan tersebut dengan rayuan balas oleh responden-responden terhadap kuantum. Dalam rayuan ini, perayu-perayu berhujah bahawa sejarah janji temu-janji temu si mati dengan mereka menunjukkan bahawa diagnosis, rawatan dan kebenaran keluar dalam setiap kejadian adalah wajar dan bahawa mereka tidak D cuai. Mereka berhujah bahawa pandangan pakar perubatan menyokong pendirian mereka bahawa gejala berterusan bagi tempoh masa munasabah sebelum mewajarkan siasatan untuk kanser kolon boleh dipertimbangkan. Perayu-perayu berhujah bahawa hakim perbicaraan adalah salah dalam, antara lain, (a) tidak mempertimbangkan keterangan mana-mana saksi-saksi pakar E perubatan tersebut yang memberi keterangan semasa perbicaraan dan menentukan isu kecuaian berdasarkan pandangannya sendiri (b) gagal untuk menilai bahawa enam kali keracunan makanan dalam masa 20 tahun dan sembilan bulan adalah bukan luar biasa dan tidak, dengannya sendiri, mengenakan kewajipan ke atas perayu-perayu untuk menjalankan siasatan F selanjutnya terutamanya apabila si mati membuat aduan pada setiap kejadian dalam masa 24 jam (c) kerana gagal untuk menilai bahawa ia adalah gejala pelik dan tanda-tanda pada 15 Disember 2000 yang membawa perayu pertama untuk menyiasat selanjutnya dan mendapati kanser kolon.

G **Diputuskan**, membenarkan rayuan, menolak rayuan balas dan mengetepikan penghakiman Mahkamah Tinggi:

(1) Melihat semula kepada fakta dan keterangan dan mengguna pakai garis panduan yang ditetapkan oleh Mahkamah Persekutuan dalam kes *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 dan mengambil H kira bahawa dalam tempoh masa 20 tahun hampir kesemua aduan berkaitan si mati semasa lawatannya yang ke lapan dirawat sewajarnya oleh perayu-perayu, adalah dapatan mahkamah ini bahawa tiada tribunal munasabah yang secara betul menilai fakta dan undang-undang akan I mencapai kepada kesimpulan bahawa perayu-perayu adalah bertanggungjawab. Mahkamah berpuas hati perayu-perayu telah bertindak secara munsabah dan logik dan telah memperolehi dengan betul fakta mereka (lihat perenggan 57(c)).

(2) Dalam kes ini tiga pakar perubatan memberi pandangan mereka: PW1

untuk responden-responden dan DW3 dan DW4 bagi perayu-perayu. Tidak satupun keterangan pakar diragui atau dipadamkan daripada rekod-rekod. Ia adalah salah arah serius oleh pihak hakim perbicaraan kerana tidak mengendahkan pandangan pakar perubatan atas subjek untuk menangani 'standard of care' terutamanya berkaitan kecuaian perubatan, melanggari garis panduan-garis panduan yang ditetapkan dalam kes *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; [1957] 1 WLR 582, *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151 dan juga kes *Foo Fio Na*. Selanjutnya, ia juga tidak mematuhi Akta Keterangan 1950. Percubaan hakim perbicaraan dengan seorang diri untuk menangani isu 'standard of care' tanpa menimbang kesemua keterangan pakar perubatan melemahkan integriti proses pembuatan keputusan yang memerlukan mahkamah rayuan untuk memberi tiada pilihan lain tetapi untuk membatalkan keputusan *in limine* (lihat perenggan 57(b)).]

Notes

For cases on medical negligence, see 12(1) *Mallal's Digest* (5th Ed, 2015) paras 1589–1603.

Cases referred to

Best v Wellcome Foundation Ltd [1994] 5 Med LR 81, SC (refd)
Bolam v Friern Hospital Management Committee [1957] 2 All ER 118; [1957] 1 WLR 582, QBD (refd)
Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151, HL (refd)
Catledge v E Jopling & Sons Ltd [1963] 1 All ER 341, HL (refd)
Chin Keow v Government of Malaysia & Anor [1967] 2 MLJ 45, PC (refd)
Dr Khoo James & Anor v Gunapathy d/o Muniandy and another appeal [2002] 2 SLR 414, CA (refd)
Dr Soo Fook Mun v Foo Fio Na & Anor and another appeal [2001] 2 MLJ 193, CA (refd)
Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171 (refd)
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593, FC (folld)
Foo Fio Na v Dr Soo Fook Mun & Ors [2002] 2 MLJ 129, FC (refd)
Foo Fio Na v Hospital Assunta & Anor [1999] 6 MLJ 738, HC (refd)
GD Searle & Co v Gunn [1996] 2 NZLR 129, CA (refd)
Hucks v Cole [1993] 4 Med LR 393, CA (refd)
Invercargill City Council v Hamlin [1996] 1 All ER 756; [1996] 1 NZLR 513, PC (refd)
Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128, FC (refd)
Loveday v Renton [1990] 1 Med LR 117, QBD (refd)
Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635, HL (refd)
Nik Nazmi bin Nik Ahmad v PP [2014] 4 MLJ 157; [2014] 4 CLJ 944, CA (refd)

Nik Noorhafizi bin Nik Ibrahim & Ors v PP [2013] 6 MLJ 660; [2014] 2 CLJ 273, CA (refd)
Roe v Ministry of Health and Others; Woolley v Same [1954] 2 All ER 131, CA (refd)
Rogers v Whitaker 16 BMLR 148; [1992] 175 CLR 479, HC (refd)
Sidaway v Bethlem Royal Hospital Governors and others [1985] 1 All ER 643; [1985] 1 AC 871, HL (refd)
Teh Guat Hong v Perbadanan Tabung Pendidikan Tinggi Nasional [2015] 3 AMR 35, HC (refd)
Whitehouse v Jordan and another [1981] 1 All ER 267, HL (refd)

Legislation referred to

Civil Law Act 1956 s 3
Courts of Judicature Act 1964 ss 60, 96, 96(a)
Evidence Act 1950 ss 45, 46, 51
Federal Constitution
Limitation Act 1953 s 6(1)

Appeal from: Civil Suit No 22–19 of 2006 (MT-4) (High Court, Penang)

Darryl Goon (Maidzuara Mohammed with him) (Raja Darryl & Loh) for the appellants.
N Rajivan (Mohd Reza Rahim with him) (Reza Rahim & Rajivan) for the respondents.

Hamid Sultan JCA:

[1] The appellants' ('the first and second defendants') appeal against the decision of the learned High Court judge who found them liable in respect of a claim anchored by the respondents ('the plaintiffs') in medical negligence. The respondents have also a cross appeal relating to quantum only.

[2] It was submitted by the learned counsel for the appellants, the standard of care and the test applicable in relation to diagnosis or treatment is still *Bolam* test and that test is dependent on the view of a responsible body of medical practitioners. The appellant relied heavily on the Court of Appeal decision of *Dr Soo Fook Mun v Foo Fio Na & Anor And another appeal* [2001] 2 MLJ 193 (see *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; [1957] 1 WLR 582). The proposition stated by the learned counsel in the first instance did not subscribe to the development of case laws in England, Malaysia, Australia, etc (see *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151; *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 *('Foo Fio Na')*). The learned counsel also argues that the Federal Court decision in the *Foo Fio Na*'s case will not be applicable in this case and says it is related to medical advice. The learned counsel makes a distinction by saying

Bolam's case is related to diagnosis and treatment and the case of *Rogers v Whitaker* 16 BMLR 148; [1992] 175 CLR 479 relates to advice or information to patient. And asserts that the fact of the instant case relates to diagnosis and treatment and in consequence *Bolam* test must be made applicable.

[3] After having heard the submission of the parties, we reserved judgment. My learned sister Badariah bt Sahamid JCA and learned brother Prasad Sandosham Abraham JCA have read the judgment and approved the same. This is our judgment.

BRIEF FACTS AND SUBMISSION

[4] The respondents are the administrators of the estate of Saradhamani ('the deceased') who was treated for colon cancer and passed away on 8 February 2005. The first and second appellants are consultant physicians who had treated the deceased for minor ailment relating to food poisoning and gastroenteritis during a period of about 20 years from 7 January 1980–15 December 2000. On 15 December 2000, the deceased was investigated by the first appellant who discovered her colon cancer. The second appellant had last attended to the deceased on 7 May 1997 and in consequence says the writ which was filed on 12 January 2006 was time barred. However, the learned trial judge had taken the view that the action was not time barred as the cause of action accrued upon the discovery of colon cancer and not on the last date the second defendant treated her for food poisoning. The learned trial judge's reason at p 83 of the judgment reads as follows:

> From the medical record of this case, it is an undenied fact that the second defendant had seen the deceased for three occasions, the last of which was on 7 May 1997. The plaintiffs' suit was filed on 12 January 2006. Section 6 of the Limitation Act 1953 (Act 254) provides:
>
> > 6(1) Save as hereinafter provided the following actions shall not be brought after the expiration of six years from the date on which the cause of action accrued, that is to say —
> >
> > > (a) actions founded on a contract or on tort;
> >
> > ...
>
> The cause of action accrued on the fact and evidence of this case is on or about 15 December 2000 when deceased was confirmed to have suffered from colon cancer. Calculating six years from 15 December 2000, the limitation would be on or about 15 December 2006. Since plaintiffs' suit was filed on 12 January 2006, it is well within time. Therefore, s 6(1) of the Limitation Act 1953 does not apply to the second defendant.

[5] The above observation of the learned judge is consonant with the view expressed in the decision of the House of Lords in *Catledge v E Jopling & Sons Ltd* [1963] 1 All ER 341, (see *Invercargill City Council v Hamlin* [1996] 1 All ER 756; [1996] 1 NZLR 513; *GD Searle & Co v Gunn* [1996] 2 NZLR 129).

[6] It was the respondents' contention that the appellants were negligent in failing to diagnose or in misdiagnosing the deceased's colon cancer. It was contended that by reason of the appellants' negligence, the deceased suffered pain and suffering and had to undergo surgery, chemotherapy and radiation until she succumbed and passed away on 8 February 2005.

[7] It is not in dispute that during the period of 20 years, the deceased had consulted the first and second appellants about eight times. On all those occasions (except one), the diagnosis was related to food poisoning and gastroenteritis. The recovery was quick, that is to say, the deceased was discharged within 24 hours or so and the deceased did not do any follow up or complained of any persisting symptoms. The gap between visits to the consultant ranges between ten months to about two or three years. The learned judge has summarised the visit and the diagnosis done. It will be useful to repeat the same to appreciate the conclusion to this judgment, and it reads as follows:

SCHEDULE A

The patient's consultations with the first and second defendants

(1) 7 January 1980

Circumstance:	The records show that the patient was admitted into the third defendant hospital at around 3.15am by one medical officer by the name of Dr Khoo Hock Lye. The patient was seen by the first defendant later that morning at between 9am to 10am
History, signs and symptoms:	(i) Generalised abdominal colic (abdominal pain) (ii) Diarrhoea (iii) Vomited once (iv) Stools yellowish, brownish and watery (v) Took some stale food earlier in the preceding day. Had a history of frequent abdominal pain and tenderness following a repair that was carried out on her right fallopian tube at the General Hospital in Penang in 1970.
Diagnosis and management:	The patient was treated for food poisoning.
Discharge:	It is recorded that the patient 'Improved by morning' and 'Requested for early discharge'.

(2) 30 May 1983

Circumstance:	Some three years later after her last consultation, the patient came to the third defendant hospital again on 30 May 1983. She was admitted at about 9.45am The patient was seen by the first defendant. She was referred to the first defendant by a general practitioner one Dr Narmal Singh.
History, signs and symptoms:	(i) Blurred vision (ii) Headache (iii) Giddiness (iv) Nausea It was recorded that the patient was under considerable strain and that she was having heavy periods.
Tests, diagnosis and management:	A urine test and a blood test were ordered. The results were normal accept for the fact that her haemoglobin level was slightly low at 9.7gm %. As the patient had heavy menses and her haemoglobin level was lower than normal, she was referred to a consultant obstetrician & gynaecologist (one Dr Tharmaratnam) for further management. In the words of the first defendant 'The patient's symptoms of concern pointed to a gynaecological cause which required the attention of a specialist in that field, ie a consultant obstetrician and gynaecologist'. Blood test disclosed an elevated white cell count in the patient, consistent with the presence of an infection.
Discharge:	The patient was discharged in the afternoon of the following day. Based on the notes of Dr Tharmaratnam, he diagnosed uterine fibroids and advised the patient to under a hysterectomy (surgical removal of the uterus).

(3) 15 December 1992

Circumstance:	Some nine years after her last consultation, the patient came to the third defendant hospital and was admitted at around 7.50am The first defendant attended to the patient.
History, signs and symptoms:	(i) Loose stools (ii) Vomiting (iii) Diarrhoea (iv) Pain (v) Slight dehydration

	(vi) Slight distension
Tests, diagnosis and management:	The patient was already being treated and medication was given. The first defendant found the treatment and medication to be appropriate and did not interfere. The patient was diagnosed with 'Gastroenteritis' and 'Anemia'. The patient's haemoglobin level was found to be 9.9 gm %. There was no complaint of any symptoms or adverse medical signs in relation to the patient's anaemia. Blood test disclosed an elevated white cell count in the patient, consistent with the presence of an infection.
Discharge:	The patient's presenting symptoms was resolved by the following morning (within 24 hours). The patient was well enough to be discharged on 16 December 1992 after having been reviewed by the first defendant. According to the first defendant, he did advise the patient to have her anaemia investigated but this was not acceded to. Perhaps that was why it was not recorded by the first defendant.
(4) 13 October 1993	
Circumstance:	On this occasion the patient was attended to by the second defendant at about 1.45pm in the third defendant hospital.
History, signs and symptoms:	(i) Diarrhoea (ii) Vomiting (iii) Left sided abdominal pain (iv) No fever
Tests, diagnosis and management:	Diagnosed with and treated food poisoning. Blook test disclosed an elevated white cell count in the patient, consistent with the presence of an infection.
Discharged:	Patient was better with observations normal and she was discharged the following day on 14 October 1993.
(5) 28 August 1994	
Circumstance:	Almost a year later the patient presented with slight abdominal pain. She was attended to by the medical officer and the second defendant in the third defendant hospital.
History, signs and symptoms:	(i) General condition fair (ii) Slight abdominal pain

	(iii) Loose stools (iv) Vomiting (v) Abdominal cramps (vi) No pallor
Tests, diagnosis and management:	Patient was diagnosed with and treated for food poisoning. Blood test was ordered but was not carried out as the patient insisted on discharge.
Discharged:	Patient was well by 8am and insisted on discharge. Patient was discharged in the morning of 28 August 1994.

(6) 7 May 1997

Circumstance:	Almost three years later the patient presented with colicky abdominal pain at around 10pm on 7 May 1997. She was attended to by the medical officer and the second defendant in the third defendant hospital.
History, signs and symptoms:	(i) Colicky abdominal pain (ii) Nausea (iii) No vomiting (iv) Diarrhoea (v) No fever
Tests, diagnosis and management:	Patient was diagnosed with and treated for food poisoning. Blood test disclosed an elevated white cell count in the patient, consistent with the presence of an infection.
Discharged:	Patient was well on the morning of 8 May 1997. Patient no longer had diarrhoea or pain.

(7) 5 October 2000

Circumstance:	Some three years five months later the patient with abdominal pain, diarrhoea and vomiting at around 5pm on 5 October 2000. She was attended to by the medical officer and the first defendant in the third defendant hospital.
History, signs and symptoms:	(i) Abdominal pain (ii) Diarrhoea (iii) Vomiting (iv) Febrile (v) Pain (vi) Mild pallor (vii) No Jaundice or shortness of breath

	(viii) No oedema
Tests, diagnosis and management:	Patient was diagnosed with and treated for food poisoning. Blood test disclosed an elevated white cell count in the patient, consistent with the presence of an infection.
Discharged:	Patient was well on the morning of 6 October 2000 and she was discharged. Diarrhoea and vomiting had ceased.
(8) 15 December 2000	
Circumstance:	Slightly over two months after her last visit, the patient called at the first defendant clinic. This was unlike the previous occasions where she came through the Accident & Emergency upon an acute/urgent event. The patient was admitted.
History, signs and symptoms:	(i) Intermittent abdominal pain (ii) Pain was on both sides of abdomen (iii) Pain after every meal (iv) No vomiting (v) No constipation (vi) Stools normal (vii) No tenderness in abdomen
Tests, diagnosis and management:	first defendant ordered endoscopy, ultrasound of the abdomen and a barium enema. Tests were carried out on the patient's stools and blood. Patient was referred to a surgeon Dato' Dr Peter Vanniasingham for further treatment and management. Patient was subsequently diagnosed with an 'apple core' malignant tumour, which was later confirmed to be cancer of the colon. The patient then underwent a hemicolectomy (surgery) on 20 December 2000 under Dato' Dr Peter Vanniasingham.

[8] Learned counsel for the appellants says that, the chart in respect of the deceased's visit to the consultant, the diagnosis, treatment and discharge were appropriate and did not demonstrate any form of negligence and relies on experts' evidence and journal, and/or literature to substantiate the argument. The evidence of experts for the appellants and the medical journal and/or literature clearly says that the symptoms must be persisting for some reasonable period of time before investigation for colon cancer will be appropriate.

[9] The learned counsel for the appellants complain that the learned trial judge had rejected the expert evidence of the respondent ('PW1') as well as the

appellants' expert evidence ('DW3') and ('DW4') and proceeded to find negligence on the part of the appellants. That part of the judgment, inter alia, reads as follows:

> As to the expert opinions of PW1 and DW3, I make no finding as to which of their opinions that I would prefer save for some of the evidence that has been deliberated hereinabove.

[10] The learned counsel for the appellants also complains that DW4 evidence was rejected in toto on the grounds that he was a member of the Medical Protection Society. That part of the judgment reads as follows:

> ... It is a fact that DW4 had not seen or treated the deceased before she was diagnosed with colon cancer. His report is based on his opinion from medical records and pleadings submitted to him. As a member of the Medical Protection Society and being so requested by the society's solicitors acting for the defendants to prepare the report, one cannot erase the element of doubt in the report so prepared and the independence of DW4's opinion. Howsoever it may be, as long as his opinion and product are tainted with the probability of non-independence, it would be unsafe for the court to rely on such evidence to ensure a fair trial. DW4's position is somewhat similar to Dr Gibson in *Foo Fio Na v Hospital Assunta & Anor* and thus, although this court may have some reservation, this court is bound by the decision held by the Court of Appeal as cited to hold that the evidence of DW4 being a member of the Medical Protection Society in which first and second Defendants are also members, as Dr Gibson, is therefore self-serving as probably, he has an interest in the decision to favour the defendants and his evidence could not therefore be relied upon. In the circumstances, no weight can be accorded to DW4's expert opinion.

[11] The submission of the learned counsel for the appellants in respect of this appeal can be summarised as follows:

(a) the learned trial judge erred in refusing to admit the expert evidence of DW4 merely because he was a member of a society in London of which the defendants are also members — the evidence of DW4, who like the defendants is also a consultant physician, would have been materially useful to the court;

(b) the learned trial judge erred in rejecting or refusing to make any finding on the testimony of the other two medical experts, PW1 and DW3, and supplanting the absence of medical expertise with his own personal views;

(c) the learned trial judge failed to appreciate that as a matter of pure reason, six bouts of food poisoning in 20 years nine months is not remarkable and does not per se warrant a duty to be imposed on the defendants to investigate further, particularly when on those six occasions, the deceased was diagnosed and treated and her ailment resolved within 24 hours;

(d) the learned trial judge failed to appreciate that no reasonable court could impose a duty on medical doctors to conduct further investigations into a patient when there is no indication for any such investigation and the doctors cannot be expected to simply investigate without any reason to believe that there is a need for such investigation, without even knowing what to investigate for or where to investigate;

(e) the learned trial judge failed to fully appreciate the importance of signs and symptoms to medical doctors and that it was the difference in signs and symptoms on 15 December 2000 that led the first defendant to investigate further, leading to the discovery of the colon cancer;

(f) the learned trial judge failed to appreciate that the Federal Court's decision in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 was one that pertained to the giving of advice and diagnosis and did not warrant the rejection of all medical expert opinions and the supplanting of the court's own views to arrive at the applicable standard of care;

(g) the learned trial judge failed to appreciate that the limitation period under s 6 of the Limitation Act 1953 runs from the accrual of the cause of action and therefore the action against the second defendant is clearly time-barred;

(h) the learned trial judge failed to appreciate that the colon cancer was not caused by the defendants or either of them and the effect thereof in regard to the doctrine of causation; and/or

(i) the learned trial judge erred in awarding damages for pain and suffering when it was clear that the pain and suffering of the deceased was due to the colon cancer and not to any act, omission or negligence on the part of either defendant.

JURISPRUDENCE RELATING TO CASES IN MEDICAL NEGLIGENCE

[12] There are a number of excellent articles, setting out the development of case laws relating to medical negligence and the applicable test and/or its distinction in our law journals. We do not wish to set them out here in detail (see *The Medical Profession, Societal Demands and Developing Legal Standards* [2014] 5 MLJ cxxxvii; *Critical Analysis And Acceptability Of Foo Fio Na v Dr Foo Sook Mun & Anor [2007] 1 MLJ 593: Valid Concerns?* [2010] 1 MLJ xlv; *Spousal Consent and Medical Negligence: A Bridge Too Far?* [2014] 4 MLJ cix).

[13] What is important to note is that, what is described as a 'test' are in actual fact just guidelines by the court to deal with the issue of medical negligence, taking into consideration the facts, circumstances as well as the justice of the case. To describe guidelines as a 'test' in the manner asserted by the

appellants, impinges on the jurisdiction and power of the Malaysian court in dealing with a case and elevates the 'test' of a foreign jurisdiction to legislative effect.

[14] The law on medical negligence as a starting point could be stated as set out in the Federal Court in the case of *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128 where Salleh Abbas FJ (as he then was) observed:

> The law on medical negligence is clear enough but its application is often difficult as facts and circumstances are not the same in each case and so must vary from case to case. For the purpose of this judgment it is necessary to state, even if briefly, the law on the subject so as to guide us in determining on the facts of this case whether Dr Susila and the Government are guilty of negligence. A doctor's duty towards his patient is that he has to exercise a fair and reasonable standard of care and skill, ie the skill of an ordinarily competent medical practitioner (*R v Bateman* [1925] All ER Rep 45). Taking this as a guide we now proceed to examine the facts.

[15] A useful dicta (cited in *Foo Fio Na*) explaining the role of court was advocated in the Irish case of *Best v Wellcome Foundation Ltd* [1994] 5 Med LR 81, where Finlay CJ stated as follows:

> Function which a court can and must perform in the trial of a case in order to acquire a just result, is to apply *common sense* and a careful understanding of the logical and likelihood of events to conflicting opinions and conflicting theories concerning a matter of this kind. (Emphasis added.)

[16] Another guiding principle was enunciated by the Federal Court in *Foo Fio Na*'s case which derives from the quote of Lord Woolfe's lecture, where it was stated that the phrase 'Doctor knows best' should now be followed by the qualifying words 'if he acts reasonably and logically and gets his facts right'. If the doctor had done so, it absolves him from liability even though his conduct had caused the patient injury, pain, suffering as well as damages.

[17] The Court of Appeal in *Dr Soo Fook Mun v Foo Fio Na & Anor And another appeal* [2001] 2 MLJ 193 had defended the applicability of *Bolam* test in Malaysia. The court, inter alia, held:

> (1) Nothing is clearer in adjectival law than a litigant's right to have his interlocutory applications heard and dealt with. In the present case, Dr Soo had a legitimate expectation to have his application for particulars heard and determined according to law. If he was unhappy with any decision made in respect of his application, he was entitled to appeal. The failure of the High Court to hear and determine Dr Soo's application for particulars therefore occasioned a most serious and fundamental miscarriage of justice. It not only deprived him of his basic right to have his application heard but it also deprived him of the substantive and valuable right to appeal against any decision made against him. By

refusing to determine his application the High Court effectively precluded him from going further: no decision and so no appeal. The way in which the case was handled by the trial judge was an extreme example of procedural unfairness and oppression (see p 201A-D).

(2) During the trial a far more wide-ranging attack of an unpleaded case of negligence was raised against Dr Soo and the Hospital. Both Dr Soo and the Hospital suffered serious prejudice by reason of having to meet the unpleaded charges of negligence. Though counsel for the plaintiff sought to defend his position by relying on the usual difficulty that a plaintiff in a medical negligence case faces in trying to prove negligence against a doctor, in the instant case, the plaintiff had the benefit of the advice of the expert called by her. It was therefore open to her in the usual way to administer interrogatories to the defendants to ascertain what, if anything, had been done wrong during the surgery. The plaintiff could not complain for the failure of her solicitors to resort to the several procedural lines of attack provided to a litigant by rules of court (see pp 206F–207A).

(3) The plaintiff's case had to do with causation and the burden of proving causation remained throughout with the plaintiff. However the plaintiff's medical evidence when placed at the highest merely rendered uncertain the cause for her tragic condition. The written judgment delivered some four years after the conclusion of the trial did not also contain any direction on the burden of proof of causation that lay upon the plaintiff (see pp 202F, 205B, E-F).

(4) A long delay in delivering judgment, such as the four year delay in the instant case, has the effect of diminishing the weight that the Court of Appeal normally lends to the views upon the credibility of witnesses made by a trial court. The longer the delay in delivery of a judgment after trial, the less weight the views of the trial judge are entitled to (see p 205H-I).

(5) It is a common occurrence for experts on one side to be present in court during the evidence of the other side. This is to enable the expert not only to advice counsel during cross-examination but also to comment on the expert evidence of the other side when he in turn gives evidence. It avoids surprise and delay. If for any reason, an expert is unable to be present when the other side is giving evidence, it is perfectly proper for him or her to later study the notes of the evidence to ascertain the nature of the evidence given (see p 207B-D).

(6) The test on the standard of proof of medical negligence that has always been used in the Malaysian jurisdiction is the test formulated by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 ('the *Bolam* test'). The Court of Appeal ought not to alter the approach for two reasons. Firstly, as a matter of precedent it is not open to the Court of Appeal as an intermediate court of appeal to alter the law as that is a function reserved for the apex court. Secondly, as a matter of practical justice, the *Bolam* test places a fairly high threshold for a plaintiff to cross in an action for medical negligence and it is right that it be so. If the law played too interventionist a role in the field of medical negligence, it will

lead to the practice of defensive medicine. The cost of medical care for the man on the street would become prohibitive without being necessarily beneficial. For the time being, the *Bolam* test maintains a fair balance between law and medicine (see pp 207E, 208A-B).

Obiter:

(1) There may be particular cases where an inference of causation may be readily drawn against a defendant warranting an explanation from him. In those circumstances, it may be entirely proper for the court to look to the defendant for a reasonable explanation negativing causation. This is not a rule of law but a mere rule of common sense (see p 202F-G).

(2) In practice one finds it most difficult to get one doctor to testify against another. In fact it is a matter of notorious repute that doctors in this country make the most reluctant witnesses against their brethren (see p 206H).

[18] In countries like Malaysia which subscribes to constitutional supremacy, the courts hand cannot be tied down based on case laws which originate from other jurisdiction or for that matter in Malaysia when it relates to facts (see s 3 of the Civil Law Act 1956). The courts here are supreme arbiter of what is right and wrong and are bound to decide a case based on the facts and law and the Constitution, (see *Nik Noorhafizi bin Nik Ibrahim & Ors v Public Prosecutor* [2013] 6 MLJ 660; [2014] 2 CLJ 273; *Nik Nazmi bin Nik Ahmad v Public Prosecutor* [2014] 4 MLJ 157; [2014] 4 CLJ 944; *Teh Guat Hong v Perbadanan Tabung Pendidikan Tinggi Nasional* [2015] 3 AMR 35).

[19] The concept of 'test' is much rigid and attempts to suggest judicial decision making process into science, though law falls into the category relating to arts. For example, litmus test, blood test, urine test, etc are in fact scientific tests and upon application of specific formula and methodology, it will give results expected of the test. The same rigidity cannot be made applicable to doctors in the pretext of medical science in the field of diagnosis, treatment and advice to say it will give the expected result. In consequence, courts supervision on conduct of doctors cannot be compromised by medical judgment that too when experts can be perceived to be partisan.

[20] Medical science is not a precise science and in consequence there are risks associated with the judgment of doctors, taking into consideration their years of experience, speciality, etc and the application of the practice and procedures; which need to be balanced with the essential service they provide for the stakeholders. As any other professionals, they too learn by trial and error and courts have taken cognisance of their plight. This point was well articulated by Lord Denning LJ in *Roe v Ministry of Health and Others; Woolley v Same* [1954] 2 All ER 131 where His Lordship observed:

> If the anaesthetists had foreseen that the ampoules might get cracked with cracks that could not be detected on inspection they would, no doubt, have dyed the phenol a deep blue; and this would have exposed the contamination. But I do not think their failure to foresee this was negligence. It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right. That is just what happened here.

[21] The above case will also show that the English courts have demonstrated that the principles of negligence related to medical negligence are not based on the same criteria as ordinary negligence cases. This distinction must be kept in mind to appreciate the distinction, approach and compromises case laws from time to time advance in relation to medical negligence jurisprudence. This point was well articulated in *Bolam*'s case by McNair J as follows:

> Before I turn to that, I must explain what in law we mean by 'negligence'. In the ordinary case which does not involve any special skill, negligence in law means this: Some failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do; and if that failure or doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Counsel for the plaintiff put it in this way, that in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent. Counsel for the plaintiff was also right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds. That again is unexceptionable. But the emphasis which is laid by counsel for the defendants is on this aspect of negligence: He submitted to you that the real question on which you have to make up your mind on each of the three major points to be considered is whether the defendants,

in acting in the way in which they did, were acting in accordance with a practice of competent respected professional opinion. Counsel for the defendants submitted that if you are satisfied that they were acting in accordance with a practice of a competent body of professional opinion, then it would be wrong for you to hold that negligence was established. I referred, before I started these observations, to a statement which is contained in a recent Scottish case, *Hunter v Hanley* 1955 SC 200; 1955 SLT 213 at p 217), which dealt with medical matters, where the Lord President (Lord Clyde) said this:

In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.

If that statement of the true test is qualified by the words 'in all the circumstances', counsel for the plaintiff would not seek to say that that expression of opinion does not accord with English law. It is just a question of expression. I myself would prefer to put it this way: A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: 'I don't believe in anaesthetics. I don't believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century'. That clearly would be wrong.

[22] What the courts do not condone is a job badly done, neglecting the interest of the patient. Justice Gopal Sri Ram in one of his articles, *The Standard of Care: Is The Bolam Principle Still The Law?* [2000] 3 MLJ lxxxi says:

It may come somewhat as a surprise to a layman in Malaysia that the standard according to which members of the medical profession in this country falls to be judged today rests upon principles laid down almost two centuries ago in Great Britain. True that there has been some refinement over time. But the basic fabric remains unchanged. And, judging by the tenor of the language employed, it would seem that there was as much reluctance in those days, for courts, to find a medical practitioner guilty of negligence. What appears to have been required to be established is 'the most brutal inattention and neglect' on the part of the medical attendant (see *Pippin v Sheppard* (1822) 11 Price 400; (1822) 147 ER 512).

Between 1800 and 1957, there were a number of occasions on which the courts of the United Kingdom had to deal with the thorny question as to what amounts to

professional negligence in a doctor. Several cases decided during this period continue to be regarded as high authority (see, for example, (i) the remarks of Lord Ellenborough in *Seare v Prentice* (1807) 8 East 348; and (ii) the direction of Tindal CJ, to the jury in *Lanphier and Wife v Phipos* [1835–42] All ER Rep 421). This paper is not the appropriate place to found a discussion of them. But it is not out of place to mention two landmarks; both cases that influenced the formulation of what have come to be known to members of the legal profession as 'the *Bolam* test'.

The first is the Scottish case of *Hunter v Hanley* 1955 SC 200 which Lord Clyde (the Lord President) said at p 204:

In the realm ... skill would be guilty if acting with ordinary care.

The second is the decision of the Court of Appeal in *Roe v Ministry of Health and Others; Woolley v Same* [1954] 2 All ER 131. Two passages from the judgment of Denning LJ, merit recall. The first is at p 137 of the report, where he said:

If the anaesthetists ... here.

The other passage appears at p 139 of the report. It reads:

These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.

These two cases dealt with the standard of care expected of a medical attendant in the field of diagnosis and treatment. What remained uncovered by authority was the area of patient advisement. That came in 1957. It was in the case of *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

[23] It is not correct for the appellant to argue that *Bolam*'s case has relevance only to diagnosis and treatment and not to medical advice. *Bolam* principle applies to advice, diagnosis and treatment though the Malaysian position presently is that it does not apply to advice. This point is reflected in the judgment itself. McNair J on this issue observed:

The plaintiff's case primarily depends on three points. First, it is said that the defendants were negligent in failing to give to the plaintiff a warning of the risks involved in electro-convulsive therapy, so that he might have had a chance to decide whether he was going to take those risks or not. Secondly, it is said that they were negligent for failing to use any relaxant drugs which admittedly, if used, would have excluded, to all intents and purposes, the risk of fracture altogether. Thirdly — and this was, I think, the point on which counsel for the plaintiff laid the most emphasis — it is said that if relaxant drugs were not used, then at least some form of manual control beyond shoulder control, support of the chin, and placing a pillow under the back, should have been used.

[24] The concept of 'guidelines' as opposed to test in the Malaysian context is more flexible and gives wider room for the court to apply the guidelines according to the facts of the case and come to a just decision with variations, if any as may be necessary, whether the judicial precedent relied on is from Malaysia or other jurisdiction.

[25] In essence, whether it is *Bolam*, *Bolitho*, *Rogers v Whitaker* or *Foo Fio Na* test, it must be read as guidelines only and the courts are obliged to follow stringently the guidelines closely to arrive at a just decision on the facts of the case by doing a balancing exercise on the rights, obligation of the parties and circumstances of the case. No one 'test' or what we like to call as guidelines, may suit the facts of the case.

[26] A useful guideline in medical negligence cases is always for the trial court to keep in mind the salutary words of Lord Denning in *Hucks v Cole* [1993] 4 Med LR 393, where His Lordship asserted that to find liability against a doctor 'his conduct should be deserving of censure or inexcusable'. That is to say, the threshold for the plaintiffs to succeed is high in contrast to ordinary negligence cases. However, even though the threshold is high for the plaintiff, once duty of care as well as standard of care has been breached and it is established against the doctor, case laws have placed the evidential burden on the doctor to rebut the plaintiffs' allegation when such allegation is supported by expert evidence to say the doctor has not satisfied the standard of care, expected of his professional standing. In *Bolam*'s case, Mc Nair J has suggested a guideline to determine if the doctor has breached the standard of care. His Lordship's guideline reads as follows:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

[27] The facts of *Bolam*'s case as said earlier, not only relates to diagnosis and treatment but also to medical advice. One of the articles published in the Malayan Law Journal on this point reads as follows:

> The *Bolam* test was applied to the medical aspects of diagnosis, advice and treatment.

[28] Cases and articles assert that *Bolam*'s case advocates 'medical judgment'. In *Sidaway v Bethlem Royal Hospital Governors and others* [1985] 1 All ER 643; [1985] 1 AC 871, Lord Scarman opined:

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible

A body of medical opinion even though other doctors adopt a different practice. *In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment*. (Emphasis added.)

B **[29]** That is to say, the trial court is bound by the medical opinion and will not find the doctor negligent as long as there is a respectable body of medical opinion that supports his action. 'Medical judgment' proposition impinges on the Malaysian court's role to adjudicate on the matter and in the context of Evidence Act 1950, opinion of experts is not meant to be the last say on the issue. Judicial supervision of the court on the conduct of any body or person C cannot be curtailed by any judicial decision per se unless such protection is given to the class of person by the Federal Constitution. In addition, the patient being a layperson, ordinarily may not have the financial means and may also be at a disadvantage as he may have difficulty to bring 'respectable body of medical D opinion' to match the doctor's expert's evidence. In consequence, judicial supervision and determination will be of assistance to the patient in dealing with medical negligence cases, which is also part of our jurisprudence to do so.

E **[30]** *Bolam*'s case in our view, does not in any way attempt to impinge on the role of the Malaysian court to decide on the issue of negligence independently after weighing experts' medical evidence. It is not totally correct to say '*the standard of care is a matter of medical judgment*' in the Malaysian context. Further, under the Evidence Act 1950, an expert view, in order to qualify as F representative of a 'responsible body of medical opinion had to satisfy the threshold test of logic', (see *Dr Khoo James & Anor v Gunapathy d/o Muniandy and another appeal* [2002] 2 SLR 414 ('*Dr Khoo James*')). This proposition was well articulated in the case of *Bolitho*.

G **[31]** In *Dr Khoo James*'s case, the Singapore court on the issue of logic, inter alia, held:

> [3] The threshold test of logic is an essentially two-stage inquiry. The first inquiry is whether the expert had directed his mind at all to the comparative risks and benefits relating to the matter. The second inquiry relates to whether the medical expert had H arrived at a 'defensible conclusion'. This connotes the satisfaction of two concepts. First, the medical opinion must be internally consistent on its face. It must make cogent sense as a whole, such that no part of the opinion contradicts with another. Second, the opinion should not fly in the face of proven extrinsic facts relevant to the matter. It should not ignore or controvert known medical facts or advances in I medical knowledge.
>
> [4] Although *Bolam* represents the starting point for the standard of care for all professionals, its specific test refers to the medical profession and the willingness of the court to adjudicate over differing opinions in other professions should not be transposed to the medical context.

[32] A brief case analysis of leading cases relating to medical negligence will demonstrate that the courts were not setting out definitive test for medical negligence case, but in actual fact, were suggesting useful guidelines to reach a just conclusion, keeping in mind the traditional approach of the courts, only to find liability against doctors when it really warrants so:

(a) in *Bolam*'s case, the plaintiff who was suffering from mental illness was advised to undergo electro-conclusive treatment, without being advised of the risk of fracture involved, though the risk was of one in ten thousand. It was said that the use of relaxant drugs would have excluded the risk of fracture. However, there was differing medical opinion on the issue and also risk related to use of relaxant drugs. The matter was tried by jury and the directions to the jury were:

(i) a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view.

(ii) that the jury might well think that when a doctor was dealing with a mentally sick man and had a strong belief that his only hope of cure was submission to electro-convulsive therapy, the doctor could not be criticised if, believing the dangers involved in the treatment to be minimal, he did not stress them to the patient.

(iii) in order to recover damages for failure to give warning the plaintiff must show not only that the failure was negligent but also that if he had been warned he would not have consented to the treatment;

(b) from the directions to the jury, it is clear that the court has set out clear parameters for the decision making process of the jury. The jury found the doctor not liable. Two paragraphs of what McNair J said is worth mention. In respect of medical negligence, His Lordship raised a higher threshold for the plaintiff to establish and to find liability. This was done through the extended concept of 'standard of care'. In ordinary negligence cases, the issue basically will be whether there was a duty of care, if so whether it was breached, and if yes whether the breach was the direct cause of the injury and if so whether the plaintiff suffered damages. In medical negligence, the plaintiff's complaint that there was a breach of duty of care without establishing the doctor's conduct will not be in accordance to the standard required by law. On the issue of standard of care, McNair J says:

> Some failure to do some act which a reasonable man in the circumstances would do or do some act which a reasonable man in the circumstances would not do and if that failure or doing of that act results in injury then there is a cause of action. In an ordinary case it is generally said, that you judge that, by the action of the man in the street. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then

A

> the test whether there has been negligence ... is the standard of the ordinary skilled man exercising and professing to have that special skill. *That is perfectly a correct statement, as long as it is remembered that there may be one or more perfectly proper standards; and if the medical man conforms with any one of those proper standards then he is not negligent.* (Emphasis added.)

B

(c) on the issue of differing medical opinion and advice, Mc Nair J states:

> Among those skilled in the profession and experienced in this form of therapy, however, there were two bodies of opinion, one of which favoured the use of relaxant drugs or manual control and the other of which, thinking,
C
> that the use of these drugs was attended by mortality risks, confined the use of relaxant drugs to cases when there were particular reasons for their use. Similarly there were two bodies of competent opinion on the question whether, if relaxant drugs were not used manual control should be. So, too, different views were held among competent professional men on the question whether a patient should be expressly warned about the risk of a fracture
D
> before being treated or left to inquire what the risk was; and there was evidence that in cases of *mental illness explanation of risk might well not affect the patient's decision whether to undergo the administration of the treatment*. (Emphasis added.)

E

(d) from the above, McNair J judgment was all encompassing guidelines for advise, diagnosis and treatment without giving much consideration to the patient's right to be informed in all aspects, which jurisprudence was not in vogue then, till the development of law in *Rogers v Whitaker*;

F

(e) the *Bolam* principle which gave the medical profession much desired protection by the profession was qualified in the case of *Bolitho*, notwithstanding that the *Bolam* principle had been endorsed in a number of House of Lords' decision as well as in Malaysia, (see *Whitehouse v Jordan and another* [1981] 1 All ER 267; *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635; *Sidaway v*
G
Bethlem Royal Hospital Governors and others [1985] 1 All ER 643; [1985] 1 AC 871; *Chin Keow v Government of Malaysia & Anor* [1967] 2 MLJ 45 (PC); *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171);

H

(f) the *Bolam*'s case in essence, does not permit the court to find the doctor negligent in preference to one body of distinguished professional opinion to another. The *Bolam*'s case places a high threshold on the plaintiff to establish negligence when the defence can demonstrate differing medical opinion on the issue;

I

(g) in *Bolitho*'s case, the Court of Appeal qualified the *Bolam* principle to say that it is not the number of experts by the defence which should determine the issue but the judge had to consider the evidence, (see *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151). Farquharson LJ in the Court of Appeal observed:

> It is not enough for a defendant to call a number of doctors to say that what he had done or not done was in accordance with accepted clinical practice. It is necessary for the judge to consider that evidence and decide whether that clinical practice puts the patient unnecessarily at risk;

(h) the observation of Farquharson LJ subscribes to Malaysian jurisprudence, anchored in ss 45, 46, 51 of the Evidence Act 1950. Those Malaysian cases which had succumbed to the *Bolam* principle in toto can only be said to have failed to appreciate the dominant provision of expert opinion and its limitation encapsulated in the Evidence Act 1950. Failure to follow statutory provision in Malaysia such as the Civil Law Act 1956 and endorsing judicial precedent from elsewhere undermines the integrity of the decision making process and does not subscribe to the rule of law envisaged by the Federal Constitution. The Civil Law Act 1956, s 3 says:

> (a) in Peninsular Malaysia or any part thereof, apply the common law of England and the rules of equity as administered in England on the 7 April 1956;
>
> (b) in Sabah, apply the common law of England and the rules of equity, together with statutes of general application, as administered or in force in England on 1 December 1951;
>
> (c) in Sarawak, apply the common law of England and the rules of equity, together with statutes of general application, as administered or in force in England on 12 December 1949, subject however to subparagraph (3)(ii);

(i) in *Bolitho*'s case, the observation of Farquharson LJ was further fortified by His Lordship Dillon LJ who observed:

> ... In my judgment the court could only adopt the approach ... and *reject medical opinion on the ground that the reasons of one group of doctors do not really stand up to analysis, if the court, fully conscious of its own lack of medical knowledge and clinical experience, was nonetheless clearly satisfied that the views of that group of doctors were Wednesbury unreasonable, ie views such as no reasonable body of doctors could have held*. (Emphasis added.)

(j) the *Bolitho* principle had placed doctors in a disadvantage in contrast to a sort of privilege they enjoyed in conducting their affairs based on the *Bolam* principle. By *Bolitho*'s principle, the conduct of doctors as well as the opinion was subject to judicial scrutiny and the judge has to apply common sense to come to a just conclusion and it cannot be achieved by a mechanical process in the guise of medical judgment;

(k) the *Bolitho* principle has it genesis in many earlier cases for the court to arrive at a just decision. For example, His Lordship Stuart Smith LJ in the case of *Loveday v Renton* [1990] 1 Med LR 117, contributed as

follows:

> ... the mere expression of opinion or belief by a witness, however eminent, ... does not suffice. The court has to evaluate the witness and soundness of his opinion. Most importantly this involves an examination of the reasons given for his opinion and the extent to which they are supported by the evidence. *The judge has to decide what weight to attach to a witness's opinion by examining the internal consistency and logic of his evidence, the care with which he has considered the subject and presented his evidence; his precision and accuracy of thought as demonstrated by his answers; how he responds to searching and informed cross-examination and in particular the extent to which a witness faces up and accepts the logic of a proposition put in cross-examination or is prepared to concede points that are seen to be correct; the extent to which a witness has conceived an opinion and is reluctant to re-examine it in the light of later evidence, or demonstrates a flexibility of mind which may involve changing or modifying opinions previously held; whether or not the witness is biased or lacks the independence ... the demeanour in the witness box.* (Emphasis added.)

(l) English cases will demonstrate that the House of Lords were not prepared to abandon *Bolam* principle in toto. In *Bolitho*'s case, Lord Browne Wilkinson asserted that 'in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold the body of opinion is not reasonable or responsible'. His Lordship gave some guidelines for the court to approach the intricate subject of expert opinion as follows:

> My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice ... The use of these adjectives — responsible, reasonable and respectable — all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter;

(m) the *Rogers v Whitaker* principle which originates in 1992 from Australia is said to be confined to advice, and *Bolitho*'s case which originates in the year 1997 was said to be confined to diagnosis and treatment, though the cases themselves, including *Bolam* do not specifically say so. If there is a distinction made the credit goes to lawyers and jurist's ingenuity and is not related to principles and guidelines advocated in those cases. In *Rogers v Whitaker*, the Australian High Court observed:

> In Australia, it has been accepted that the standard of care to be observed by

> a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill ... But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade ... Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead the courts have adopted ... the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make his own decision about his life' ... ; and

(n) the *Rogers v Whitaker*'s case attempts to extend the duty of care principle between the doctor and patient to greater heights to the detriment of the doctors and giving protection for the patients, the right to be informed of the risks involved. The jurisprudence advocated in *Rogers v Whitaker*'s case was not part of the common law and arguably ought to have been legislated before it is applied by courts in the Malaysian context when it is in variance with *Bolam* principle, (see Civil Law Act 1956). The imposition of such duty was not also related to the traditional Oath of Hippocrates (or its like), the doctors are said to have taken or expected to know which the common law world was cognisant of. In consequence, it is arguable whether it was just and right to add on to the liability of doctors by case laws without appropriate legislation. The duty and obligation of the doctors for example is encapsulated in 'The Oath of Hippocrates' which reads as follows:

> I SWEAR by ... that, according to my ability and judgment, I will keep this Oath and this stipulation — to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others.
>
> I will follow that system of regiment which, *according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous*. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work.
>
> Into whatever houses I enter, I will go into them for the benefit of the sick, *and will abstain from every voluntary act of mischief and corruption*; and, further, from the seduction of females or males, of freemen and slaves.

> Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, *I will not divulge, as reckoning that all such should be kept secret*. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot. (Emphasis added.)

[33] The Hippocrates Oath written by Hippocrates is said to be one of the oldest document in history and the terms of which is held sacred by doctors. The oath must be seen as the terms of engagement between doctors and patients and notice to the world. It will appear that the English courts may have kept the Hippocrates Oath of engagement in mind when dealing with the 'standard of care' principles advocated in a conservative manner in *Bolam*'s case. That conservative guideline must be respected subject to other guidelines which are reasonably imposed by the courts from time to time which are not inimical to the said oath. The oath itself covers the 'standard of care' aspect. For example, it asserts. 'I will consider for the benefit of my patient and abstain from whatever is deleterious and mischievous' ... 'will abstain from every voluntary act of mischief and corruption'. And also the doctor undertakes 'I will follow the system of regiment which according to my ability of judgment'. The oath gives room for peer review as well as curial supervision on the conduct of doctors. The oath apparently does not cover the duty to inform the patient of the risk as advocated in *Rogers v Whitaker*'s case. The right to inform of the risk is one related to common sense and it arguably falls within the common law duty of care principle and medical opinion on the subject is irrelevant and in consequence the right to inform arguably ought not to be compartmentalised in the 'standard of care' concept.

[34] *Rogers v Whitaker* principle without being legislated arguably can be justified on the basis the duty of care principle was always part of the common law principle and to discharge the said duty, the doctor is obliged to inform the patient of the diagnosis, treatment and risk, failing which if the patient suffers damage in relation to advise, diagnosis and treatment, the court may find the doctor liable within the parameters of established general principle of negligence though in *Rogers v Whitaker*, the court refused to accept advice in the caption of duty of care.

[35] If the issue is whether the patient has a right to be informed, then it is arguably related to the duty of care principle. The answer is one related to common sense and medical opinion is not a criteria to determine the issue. However, if it extends to the nature of information and the exposure of the risk to the patient as well as the advice is correct, then it is related to standard of care as advocated by case laws though the distinction between the two has not been clearly made out. The standard of care issue which adds on to the liability of the doctors in Malaysia as advocated in *Rogers v Whitaker* must arguably be

legislated within our jurisprudence, if it is to be made as a strict test as opposed to guidelines. It must also be noted in *Rogers v Whitaker*, the court refused to separate the duty of care and the standard of care issue, and the court asserted at p 489 as follows:

> The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a single comprehensive duty.

[36] The standard of care issue as to advice, in our view, taking the principles enunciated in *Foo Fio Na*'s case, must be decided on the basis whether the doctor had acted reasonably and logically and have got the facts correct. Such an approach is harmonious with the principles of negligence as well as Evidence Act 1950. In this respect the dissenting opinion of Lord Scarman in *Sidaway*'s case will fit the equation. In the instant case, His Lordship observed:

> In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.

[37] From the grounds of judgment of *Bolam*, the practice of informing the patient of the risk was already in vogue in medical practice. There were also circumstances in which it could be considered that it would not be beneficial to tell a patient of *possible* dangers and mishaps. However, in *Rogers v Whitaker*, the court took the view that *probable* risks ought to be disclosed. (Emphasis added.) In *Rogers v Whitaker*, it was held:

> Except in the case of an emergency or where disclosure would prove damaging to the patient, a medical practitioner has a duty to warn the patient of a material risk inherent in proposed treatment. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. The fact that a body of reputable medical practitioner gave does not preclude a finding of negligence. Generally speaking, whether the patient has been given all the relevant information to choose between undergoing and not undergoing the proposed treatment is not a question the answer to which depends upon medical standards or practice.

[38] The Federal Court in *Foo Fio Na*'s case did not say in any positive terms that the *Bolam*, *Bolitho* or *Rogers v Whitaker* principles will apply in all cases of medical negligence in Malaysia. In our view, *Bolam*, *Bolitho* or *Rogers v Whitaker* principles may apply as guiding principles in medical negligence

cases in Malaysia, depending on the issues and facts and the rider the Federal Court has placed. The three cases were discussed at length by the Federal Court but the question posed to the Federal Court was not whether *Rogers v Whitaker*'s case should be applicable to all cases of medical negligence in Malaysia. Much confusion arises at times in consequence of jurist's attempting to read the case out of context.

[39] In *Foo Fio Na*'s case, the High Court allowed the plaintiff's claim in medical negligence. On appeal to the Court of Appeal, the court set aside the judgment of the High Court primarily based on procedural fairness as well as the failure of the plaintiff to establish the case according to law. All things being equal on the facts of the case, the plaintiff ought to have succeeded. The Court of Appeal grounds in the judgment was substantially related to errors committed by the trial judge as well as the plaintiff's counsel. The Court of Appeal judgment was not based on the fact that the plaintiffs did not have a good case to succeed. *Bolam*, *Bolitho* or *Rogers v Whitaker* principles were not substantially used by the Court of Appeal to demolish the trial court judgment.

[40] To appeal to the Federal Court, the plaintiffs need to obtain leave. In matters of leave, the Federal Court on established principles is not concerned whether there was in fact a miscarriage of justice in the Court of Appeal's decision, refusing to entertain a viable claim of the plaintiff. The principle to grant leave is strict in law and has nothing to do with justice, equity or good conscience and is set out in s 96 of the Courts of Judicature Act 1964. The said section reads as follows:

> 96 Subject to any rules regulating the proceedings of the Federal Court in respect of appeals from the Court of Appeal, an appeal shall lie from the Court of Appeal to the Federal Court with the leave of the Federal Court —
>
> (a) from any judgment or order of the Court of Appeal in respect of any civil cause or matter decided by the High Court in the exercise of its original jurisdiction involving a question of general principle decided for the first time or a question of importance upon which further argument and a decision of the Federal Court would be to public advantage; or
>
> (b) from any decision as to the effect of any provision of the Constitution including the validity of any written law relating to any such provision.

[41] In granting leave, the Federal Court consisting of Steve Shim CJSS, Abdul Malek and Mokhtar Abdullah FCJ confined the question of law to the particular aspect of medical negligence that relates more specifically to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment, (see *Foo Fio Na v Dr Soo Fook Mun & Ors* [2002] 2 MLJ 129). The leave was granted to consider the development of law in Australian cases. The nature of the application for leave and the grounds were described by the Federal Court as follows:

> This is an application for leave to appeal against the decision of the Court of Appeal given on 5 April 2001. The main question for which leave is sought is stated as follows: whether the *Bolam* test as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, in the area of medical negligence should apply in relation to all aspects of medical negligence.
>
> Having heard arguments from counsel for the parties concerned, we are of the view that the question posed is one of importance upon which further argument and a decision of this court would be to public advantage. In this regard, our attention has been drawn to later case jurisprudence from *Australia and other Commonwealth countries*, which it is contended, has refined the *Bolam* test to such an extent that it may now be necessary for this court to reconsider the *Bolam* test.
>
> It may be noted that in this case, the particular aspect of medical negligence relates more specifically to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment.
>
> In the circumstances, we are satisfied that the question postulated above falls within the ambit of s 96(a) of the Courts of Judicature Act 1964. Leave is therefore allowed. (Emphasis added.)

[42] The leave granted was related to medical advice which impliedly refers to *Rogers v Whitaker*'s case. It must be noted that the decision of the Court of Appeal in *Foo Fio Na*'s case which rested on technicalities, totally rejected *Rogers v Whitaker* principle and fully endorsed the *Bolam* principle. The Court of Appeal in rejecting *Rogers v Whitaker* principle had this to say:

> In the course of argument, we were referred to a number of recent cases from Australia that have departed from the *Bolam* test. These include *F v R* [1983] 33 SASR 189, *Rogers v Whitaker* 16 BMLR 148; [1992] 109 ALR 625 and *Naxakis v Western General Hospital* [1999] HCA 22 (Internet Ed). Counsel for the plaintiff urged us to follow the Australian approach and jettison the *Bolam* test. I will be less than frank if I did not say that I was at first most attracted to this suggestion. But having given the matter much anxious consideration, I have come to the conclusion that we ought not alter the approach. There are two broad reasons for this. First, as a matter of precedent, I do not think that it is open to us, as an intermediate court of appeal, to alter the law. That is a function reserved for the apex court. Secondly, as a matter of practical justice, the *Bolam* test places a fairly high threshold for a plaintiff to cross in an action for medical negligence. It is right that this be so. If the law played too interventionist a role in the field of medical negligence, it will lead to the practice of defensive medicine. The cost of medical care for the man on the street would become prohibitive without being necessarily beneficial. For the time being the *Bolam* test maintains a fair balance between law and medicine. There may perhaps come a time when we will be compelled to lower the intervention threshold if there is a continuing slide in medical standards. But that day has not yet come.

[43] In any event, the question of law posed to the Federal Court after obtaining leave was stated as follows:

Whether the *Bolam* test as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 in the area of medical negligence should apply in relation to all aspects of medical negligence?

[44] The leave will appear to be related to *Rogers v Whitaker* principle relating to advice. The question of law posed to the Federal Court relates to *Bolam* principle ignoring the *Bolitho* principle. In any event, the Federal Court held:

(1) The *Bolam* test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.

(2) There is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium than the *Bolam* test. On that the question posed to this court was answered in the negative. The appeal was allowed and the orders of the High Court on quantum are to be restored.

[45] The decision of the Federal Court only answers a question posed, ie whether *Bolam* principle should apply to all aspects of medical negligence. The question itself ignores *Bolitho*'s principle, etc. In answering the question posed, the Federal Court has rightly ruled in the negative. The negative ruling was applied to the facts of *Foo Fio Na*'s case. In consequence, the proposition of the Court of Appeal advocating the *Bolam* principle would have been a misdirection of law and the only other issue which would have remained to be decided is whether or not the technical issues relied on by the Court of Appeal is sufficient to set aside the High Court decision which decided the case on merits, taking into consideration s 60 of the Courts of Judicature Act 1964 which reads as follows:

60(1) At the hearing of an appeal the Court of Appeal shall hear the appellant or his advocate, if he appears, and, if it thinks fit, the respondent or his advocate, if he appears, and may hear the appellant or his advocate in reply, and the Court of Appeal may thereupon confirm, reverse or vary the decision of the High court, or *may order a retrial* or may remit the matter with the opinion of the Court of Appeal thereon to the trial court, or may make such other order in the matter as to it may seem just, and may by that order exercise any power which the trial court might have exercised:

Provided that the Court of Appeal may, notwithstanding that it is of opinion that

the point raised in the appeal might be decided in favour of the appellant, dismiss the appeal if it considers that no substantial miscarriage of justice has occurred. (Emphasis added.)

[46] The Federal Court allowed the appeal and affirmed the order of High Court in respect of quantum, meaning to say the Court of Appeal decision was set aside. The Federal Court's order at para 70 in *Foo Fio Na*'s case states:

[70] On that finding, we answer the question posed to us in the negative and order that this appeal is allowed with costs here, in the Court of Appeal and in the High Court to be borne by the respondents and the orders of the High Court on quantum are to be restored. The deposit is to be refunded to the appellant.

[47] The Federal Court in *Foo Fio Na* allowed the appeal, and it did not agree to the *Bolam* principle as advocated by the Court of Appeal. The Federal Court did not reject the *Bolam* principle or *Rogers v Whitaker* principle in toto but added a rider, ie to say that the court ultimately must determine whether the doctor acted reasonably and logically and got his facts right. In consequence, inter alia, of the rider, medical negligence cases in Malaysia cannot be decided by medical judgment, but it has to be by way of judicial determination. The Federal Court also had made it clear that the *Bolam* principle will not apply to advice, but *Rogers v Whitaker* principle will.

[48] The Federal Court in *Foo Fio Na*'s case dealt in great detail, the guidelines which originate from *Bolam*, *Bolitho* and *Rogers v Whitaker*. A summary of the facts of case will be useful to appreciate the Federal Court's decision in *Foo Fio Na*.

[49] The plaintiff in *Foo Fio Na* met with an accident and, inter alia, had severe injuries in the spine which resulted in closed dislocation of C4 and C5 vertebrae with bilaterally locked facets. Conservative treatment was not successful and the defendant doctor performed two operations. Before the first operation, a standard consent form was signed by the patient. After the first operation, the plaintiff was paralysed. It was subsequently discovered by one neuro surgeon that the wire loop which was placed to correct the dislocation of C4 and C5 was pressuring the spinal cord and that was the cause of total paralysis. In consequence, the doctor immediately performed the second operation but it did not remove the paralysis in full and the patient was confined to the wheel chair. The doctor had also obtained consent for the second operation but the consent form only had thumb print of the plaintiff and not her signature. There was complaint that the doctor did not give proper medical advice. On the issue of consent and risk, the Federal Court made the following observation:

[29] It is the first respondent's case that the neck injuries suffered by the appellant were as a result of the motorcar accident and if left unattended would lead to

paralysis sooner or later. It was under these circumstances that when the conservative treatment proved to be negative that the first operation was performed and when that proved unsuccessful the second operation was undertaken and on both occasions the first respondent had the expressed consents of the appellant to perform both operations.

[30] The expressed consents refer to two consent forms executed by the appellant. The first was signed by her at the time of her admission when it was not even contemplated that surgery was necessary. The second consent form showed her thumb print on the form and bearing a date after the first operation. The trial judge questioned the voluntariness of the thumb print as it was not executed in the presence of a witness as by that time she had lost all sensation to her limbs.

[31] But the issue here is not so much on the consents given for the two operations but on the risks involved and whether the appellant was warned of such risks. She had testified that had she been warned of the risks involved she would not have readily agreed to undergo the first operation.

[50] On the issue of advice, the Federal Court at para 36 held that:

[36] That said, we are of the opinion that the *Bolam* test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.

[51] The above paragraph of the judgment makes it clear that the *Bolam* principle is not to be the preferred guideline when it relates to advice. The Federal Court also acknowledged that case laws on this point is not consistent in English courts. At para 37 the court observed:

[37] Case law on this aspect of medical negligence has not been consistent in the application of the *Bolam* Principle by the English courts. One such case relates to the House of Lords' dissenting judgment of Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital & Ors* [1985] 1 AC 871. The learned judge expressed his observations in the following manner:

In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.

[52] The Federal Court at para 47 also had confirmed that the *Bolam* principle was not followed in Australia in respect of medical advice and it reads as follows:

> [47] Commonwealth jurisdictions have also declined to follow the *Bolam* test. One such case is the Australian case of *Rogers v Whitaker* [1992] 175 CLR 479, where the facts disclose that Whitaker who was almost totally blind in the right eye consulted Rogers, an ophthalmic surgeon. The latter advised her that an operation on her right eye would not only improve its appearance but would probably restore significant sight to it. Whitaker agreed to undergo surgery but it did nothing to her right eye but developed inflammation to her left eye and this led to the loss of sight of that good eye. In the Supreme Court of New South Wales Rogers was held liable in that he had failed to warn Whitaker that as a result of the surgery, she might develop a condition known as sympathetic opthalmia in her left eye. Rogers' appeal to the Court of Appeal was dismissed and in affirming that decision and following Lord Scarman's ruling in *Sidaway*, the High Court made the following pronouncements:
>
> In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* Principle has not always been applied. Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* Principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the paramount consideration that a person is entitled to make his own decisions about his life.

[53] The Federal Court also confirmed that the *Rogers v Whitaker* principle was applied in a number of cases in Malaysia, (see *Foo Fio Na v Hospital Assunta & Anor* [1999] 6 MLJ 738; *Dr Soo Fook Mun v Foo Fio Na & Anor And another appeal* [2001] 2 MLJ 193; *Foo Fio Na v Dr Soo Fook Mun & Ors* [2002] 2 MLJ 129).

[54] The Federal Court in reliance on a book on *Medical Negligence by Michael Jones* [1996] observed as follows:

> [65] Finally, we make reference to Michael Jones' book on *Medical Negligence* [1996] ed, p 95 that seems to suggest that there is a distinction between the test of negligence based on the reasonable competent man and that of the ordinary skilled man. The former makes it clear that negligence is concerned with the departures from what ought to have been done in the circumstances which is measured by reference to a hypothetical 'reasonable doctor' and the latter places considerable emphasis on the standards which are in fact adopted by the profession. He emphasises that the point is for the court to determine what the reasonable doctor

would have done, not the profession. What the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the court should set the standard of care in negligence, drawing upon the evidence presented. The *Bolam* test fails to make this important distinction between the reasonable competent doctor and the ordinary skilled doctor.

[55] At para 69 the Federal Court asserted that *Rogers v Whitaker* principle would be more appropriate and viable in contrast to the *Bolam* test. This paragraph must not be taken out of context as the Federal Court decision discusses in length that the *Bolam* principle is not appropriate to advice but *Rogers v Whitaker* principle is. Paragraph 69 of the judgment, reads as follows:

> [69] Therefore, there is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing, people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis, we are of the view that the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium then the *Bolam* test. To borrow a quote from Lord Woolfe's inaugural lecture in the new Provost Series, delivered in London in 2001, the phrase 'Doctor knows best should now be followed by the qualifying words 'if he acts reasonably and logically and gets his facts right.

[56] In essence, the Federal Court decision in *Foo Fio Na*'s case is clear that the guidelines for advice will not be predicated on the principle laid down in *Bolam*'s case and the preferred principles is related to *Rogers v Whitaker*'s case. However, whether the *Bolam* or *Rogers v Whitaker* principle is applicable, the overriding consideration for the courts is not to compromise its pedestal and its role on finding of facts as well as law, and not to find the doctor liable if he had acted reasonably and logically and got his facts right, a proposition which was not anchored in *Bolam* or *Bolitho* or *Rogers v Whitaker* case. The Federal Court's case of *Foo Fio Na* does not compromise the patient's right or doctor's role and maintains the 'relevant standard', taking into consideration the rider as well as a higher threshold for the patient to satisfy to find liability against doctors when it relates to diagnosis and treatment and a lower threshold to satisfy when it relates to medical advice. The difference is like an apple and orange and in scientific sense both the principles cannot be married together. When it relates to diagnosis and treatment, the *Bolam*'s principle is a factor to be considered, taking into consideration the *Bolitho*'s principle and ensuring the doctor is not found liable when he had acted reasonably and logically and got his facts correct.

[57] We have read the appeal record and the able submissions of the counsel. After much consideration to the submission of the respondent, we take the

view that the appeal must be allowed and the cross-appeal of the respondent must be dismissed. Our reasons, inter alia, are as follows:

(a) on the issue of limitation which is said to have set in against the second appellant, we could not find any legal reasoning on the subject matter by the learned trial judge. Our request for further submission on the limitation issue was not satisfactorily attended to by the learned counsel. As we have decided to allow the appeal on other grounds, we do not think it is necessary on the facts of this case to deal with the issue of limitation;

(b) in the instant case, three medical experts gave their opinion. PW1 gave evidence for the plaintiff and DW3 and DW4 gave evidence for the defendants. None of the expert evidence was discredited or expunged from the records. It was a grave misdirection on the part of the learned trial judge to disregard the medical expert opinion on the subject in issue to deal with 'standard of care' in particular relating to medical negligence, in breach of established guidelines set out in *Bolam*, *Bolitho*, as well as *Foo Fio Na*'s case. In addition, it also does not subscribe to the Evidence Act 1950. The learned judge single-handedly attempting to deal with the issue of 'standard of care' without weighing all the medical experts evidence undermines the integrity of the decision making process requiring the appellate court giving no other alternative but to quash the decision in limine, (see *Dr Khoo James & Anor v Gunapathy d/o Muniandy and another appeal* [2002] 2 SLR 414); and

(c) by the process of rehearing the case, we have relooked at the facts and evidence and applied the guidelines set out in the Federal Court's case of *Foo Fio Na*, which we have discussed at length earlier and took into consideration that in 20 years almost all the complaints relating to the deceased during the eight visits were appropriately attended to by the appellants. In our considered view, no reasonable tribunal properly appraised of the facts and law will come to the conclusion that the appellants are liable. We are satisfied that the appellants had acted reasonably and logically and have got their facts correct.

[58] For reasons stated above the appeal is allowed with costs and the cross-appeal on quantum is dismissed. The judgment of the High Court is set aside. We will hear the parties on costs before fixing the amount.

Appeal allowed, cross-appeal dismissed and judgment of the High Court set aside.

Reported by Ashok Kumar